MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

464

D 67242

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day, 4 hrs. 45 min.

Hospital, institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution? 1 day, 4 hrs. 45 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Hyattsville,

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3900-Hamilton St.,

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME

MILDRED ALEXANDER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 17, 1904

8. AGE: Years	Months	Days	If less than one day
42	9	27	..... hrs. ..... min.

9. Birthplace: Warsaw, Virginia (Town, county, and state)

10. Usual occupation: Social worker

11. Industry or business

FATHER

12. Name: Randolph F. Alexander

13. Birthplace: Va.

MOTHER

14. Maiden name: Mildred Lowery

15. Birthplace: Va.

16. Informant: Mrs. Arnold Hodgson (friend)

Address: 4600-30th St., Mt. Ranier, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 16, 1947 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore, Md.

18. Funeral director: Wm. J. Tickner & Sons, Inc.

Address: North & Pennsylvania Aves.

19. 8/14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13, 1947 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 July 1947 to 13 August 1947 and that I last saw h... alive on 30 July 1947

Immediate cause of death	DURATION
Pulmonary Embolus	
Due to: Carcinoma of Liver	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma Liver Date of op. 8/13/47

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. L. Etienne M. D.

Address: Berwyn, Md. Date signed 8-13-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

67243

Reg. Diat. No. 240

1. PLACE OF DEATH:
County Prince Geo Co
City or town Brandywine md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Prince Geo Co
City or town Brandywine md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Alfred Auige

3.(b) Social Security Number

4. Sex	5. Color or race	(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Nellie
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 6 - 1864

8. AGE: Years 82 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace England (Town, county, and state)
10. Usual occupation Paperhanger
11. Industry or business

FATHER
12. Name John Auige
13. Birthplace England

MOTHER
14. Maiden name Anna
15. Birthplace England

16. Informant Mrs Nellie Auige
Address Brandywine Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-5-47 (month) (day) (year)
Cemetery or crematory Emanuel
Location Rural Brandywine Md
18. Funeral director Hewitt & Lapen
Address Waldorf Md

19. Aug 5 1947 (Date rec'd by registrar) F. H. Billingsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 19 47 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Arteriosclerosis, general + Cardiovascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Alfred R. Lapen MD M. D. or Other
Address Aquasco, Md Date signed Aug 7, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a 230 67244

Reg. Dist. No. 231

1. PLACE OF DEATH: County: Prince Georges' — City or town: BERWYN (If outside city or town limits, write RURAL and give nearest town) — How long in above place of death? 4 yrs — Hospital, institution, or street address where death occurred: 9609 - 49 Ave — How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) — State: Md. — County: Prince Georges — City or town: Berwyn (If outside city or town limits, write RURAL and give nearest town) — Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: LAURA ISBELL APPOLD — **3.(b) Social Security Number:** —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	White	WIDOWED

6.(b) Name of husband ~~or wife~~: Wilbert Appold — 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 16 APRIL 1863

8. AGE: Years: 84 — Months: 4 — Days: 3 — If less than one day: ____ hrs. ____ min.

9. Birthplace: BALTIMORE, Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER — 12. Name: WILLIAM G GARRETT — 13. Birthplace: OHIO

MOTHER — 14. Maiden name: UNKNOWN — 15. Birthplace: OHIO

18. Informant: HORACE M APPOLD — Address: BERWYN

17. Burial (Burial, cremation, or removal. Which?) — Date thereof: Aug. 21 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill — Location: Suitland, Md

18. Funeral director: Wm. Lee Sons Co — Address: 300-4 St. N.E. - DC

19. 8/19/1947 (Date rec'd by registrar) — Amanda Downey, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 August 1947 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 August 1947 to 17 Aug 1947 and that I last saw h... alive on 14 August 1947

Immediate cause of death: Hypostatic Pulmonary Congestion — DURATION

Due to: Cerebral Thrombosis

Due to: Arteriosclerosis

Due to:

Other conditions: FRACTURE Left ARM

(Include pregnancy within 3 months of death)

Major findings of operation: — Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident — Date of: 8/2/47

Where did injury occur? Berwyn (City or town) (County) Md (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: Fall on porch — Injured at work? [illegible]

23. SIGNATURE: W L Etienne, M. D.

Address: Berwyn, Md — Date signed: 8-19-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07245

108

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: Prince Georges Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Georges
City or town: Maryland Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6528 Coolidge St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Armstrong, Mr Wallace

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Wh. Le	married

6.(b) Name of husband or wife: Racheal
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 14 Apr 1891

8. AGE: Years: 56 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Dairy worker

11. Industry or business: Richfield Dairy

FATHER
12. Name: Henry Armstrong
13. Birthplace: Pa

MOTHER
14. Maiden name: Sarah Anderson
15. Birthplace: Forkstville md

16. Informant: daughter - Racheal
Address: same

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-1-47 (month) (day) (year)
Cemetery or crematory: Ephesus Ch Cemetery
Location: Forestville, Md

18. Funeral director: W W Chamber
Address: 517 11th S.E. Wash D.C.

19. 8/29 1947 (Date rec'd by registrar) Amanda Dorsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 28 1947 at 2:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 1947 to Aug 28 1947 and that I last saw him alive on Aug 28 1947

Immediate cause of death	DURATION
Acute cardiac Decompensation	4 hrs.
Due to: Labor Pneumonia Rt lung	5 days.
Due to:	
Other conditions: Cardiovascular renal disease (Include pregnancy within 3 months of death)	Untermined

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Washington 19 DC Date signed: Aug 28/1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 b

67246

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 20 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 month, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 133- E. Street, N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN FREDERICK BEATLEY

3.(b) Social Security Number: 228-07-4196

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: October 24, 1897

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 24, 1897

8. AGE: Years	Months	Days	If less than one day
49	10	5	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Plumber

11. Industry or business:

FATHER
12. Name: George Beatley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha Done
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 29 1947 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D. C.

18. Funeral director: W. W. Chambers Co.

Address: 517-11th St. S.E. Wash. D.C.

19. Aug 29, 1947 (Date rec'd by registrar) Rowland & Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 29, 1947 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8, 1947 to Aug 29, 1947 and that I last saw him alive on Aug 29, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr 2 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md., Date signed: 8/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect or illegible entry is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

07247

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Prince George
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 hours
Hospital, Institution, or street address where death occurred:
Prince George General Hospital
How long in hospital or institution? 27 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Upper Marlboro Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Blandford, John

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife unknown
6.(c) If alive, give age 0 years
7. Birth date of deceased (mo., day, yr.) July 17th, 1876

8. AGE: Years	Months	Days	If less than one day
71	1	7	hrs. min.

9. Birthplace Piscataway, Maryland (Town, county, and state)
10. Usual occupation unknown
11. Industry or business unknown

FATHER 12. Name Thomas Blandford
FATHER 13. Birthplace unknown
MOTHER 14. Maiden name Catherine Spalding
MOTHER 15. Birthplace unknown

16. Informant Mrs. John Lewis
Address Upper Marlboro, Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof 8-20-47 (month) (day) (year)
Cemetery or crematory St Mary
Location Cheltenham Md
18. Funeral director Hewitt & Ryan
Address Hyattsville Md
19. 8/22 1947 (Date rec'd by registrar) Amanda Dorsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24th 1947 at 12:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 23 1947 to Aug 24 1947 and that I last saw him alive on Aug 23 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to Cardio Vascular Renal Disease	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Lance Thurston M.D. M. D. or other
Address Washington 19 DC Date signed Aug 24 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

67248

Reg. Dist. No. 234

1. PLACE OF DEATH:
County: Pr George
City or town: Piscataway
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr George
City or town: Piscataway
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Dominic Blandford

3.(b) Social Security Number: 214-12-7847

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Frances M. Blandford
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Jan 7, 1869

8. AGE: Years	Months	Days	If less than one day
78			hrs. min.

9. Birthplace: Accokeek Md (Town, county, and state)
10. Usual occupation: Retired (night watchman)
11. Industry or business: Govt project

FATHER
12. Name: Sidney B Blandford
13. Birthplace: Accokeek

MOTHER
14. Maiden name: Catherine
15. Birthplace: Accokeek

16. Informant: Frances M. Blandford
Address: Piscataway

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Aug 14-47 (month) (day) (year)
Cemetery or crematory: St Mary's
Location: Piscataway Md.

19. Funeral director: Hunter & Ryan
Address: Waldorf Md

19. 8-13 19 47 Mrs Alton Davis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 12 1947 at 9:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 4 1947 to Aug 12 1947
and that I last saw h alive on Aug 11 1947

Immediate cause of death: Cerebral Thrombosis — 8 days
due to: Auricular Fibrillation — 2 wks
due to: Arteriosclerosis — 3 yrs
due to:
Other conditions: Cataract

DURATION

(Include pregnancy within 2 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: E W Schwartz MD M. D. or other
Address: 1225 Talbot St SE Washington DC Date signed 8/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
AUG 15 1907
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67249

93d

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George
City or town: Bowie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Bowie
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Chestnut St + Tuttle St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mary Ella Boswell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Herbert William Boswell
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 27, 1870

8. AGE:

Years	Months	Days	If less than one day
77	5	19	hrs. ..... min.

9. Birthplace: Hazelwood Md Prince Georges Co Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home
FATHER 12. Name: Lafayette ?
13. Birthplace: Tidewyland
MOTHER 14. Maiden name: Margaret Virginia ?
15. Birthplace: Maryland.
16. Informant: H. W. Boswell - Son
Address: 307-70th St. Seat Pleasant Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 18 47 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cem.
Location: Wash-Bell Blvd Md.
18. Funeral director: W. W. Chambers Co
Address: 5801 Cleveland ave, Riverdale Md.
19. Aug 16 1947 Mrs. J. W. Yingling Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 16 1947, at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14 1947, to Aug 16 1947
and that I last saw h-er alive on Aug 16 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 years
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Robert S McCreary M.D.
M.D. or other
Address: 402 Main St Laurel Md Date signed: 8/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

67250

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 15M

1. PLACE OF DEATH:
County: Pro. Geo. Co.
City or town: Hyattsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5004 - 38th st
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Alice Fletcher Bratt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: James L. Bratt Jr.
6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): May 27, 1911

8. AGE: Years: 36. Months: Days: If less than one day: hrs. min.

9. Birthplace: Philadelphia Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Howard L. Fletcher
13. Birthplace: Pa

MOTHER
14. Maiden name: Blanche Fink
15. Birthplace: Pa

16. Informant: James L. Bratt Jr
Address: Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 4, 1947 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln
Location: Washington D.C.

18. Funeral director: L Weedon Sons
Address: Hyattsville Md.

19. Aug 3 1947 (Date received by registrar) James Sevvs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1, 1947 at 12.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1947 to August 1 1947 and that I last saw h[er] alive on August 1 1947

Immediate cause of death: Cerebral edema and pulmonary stasis — DURATION: 3 days

Due to: Hypertension

Due to:

Other condition: Epithelioma Jaw with General metastasis
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William A. Ryan M.D. (M. D. or other)
Address: 401 - West WE Date signed: 8/4/47


RECEIVED
AUG 5 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

67251

Reg. Diat. No. 334

1. PLACE OF DEATH:

County Prince George Co

City or town Fort Foote 2nd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 58 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr Geo Co

City or town Fort Foote

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6990 Oxon Hill Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Martha L. Brooke

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Robert W. Brooke Sr.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 21 - 1870

8. AGE: Years 76 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Newport, Maryland (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name Mortimor A. Brooke

13. Birthplace md

MOTHER 14. Maiden name Edwina Keech

15. Birthplace md

16. Informant Mr. Robert W. Brooke Sr

Address 6990 - Oxon Hill Rd. rash 20, S.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug - 13 - 47 (month) (day) (year)

Cemetery or crematory St Ignatius Cemetery

Location Oxon Hill Maryland

18. Funeral director Arthur E Simmons Jr

Address 3007 - Nichols Ave S.E.

19. Aug 10 1947 (Date rec'd by registrar) Howard J Beard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - August 19 47 at 10:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 - August 19 47 to 10 - Aug 19 47

and that I last saw her alive on 10 - Aug 19 47

Immediate cause of death	DURATION
Coronary thrombosis	1 hour
Due to Angina Pectoris	4 years
and	
Due to Hypertension	6 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harvey H. Ammerman M.D. M. D. or other

Address 5440 Silver Hill Rd. Date signed 11 Aug - 47

Suitland Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

07252

Reg. Dist. No. 272

1. PLACE OF DEATH:

County: Prince Georges

City or town: Upper Marlboro Rt #1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: none - (Home)

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Browns Sta. Upper Marlboro Rt 1

(If outside city or town limits, write RURAL and give nearest town)

Street No.: —

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Robert Emmett Brown, Robert Emmett

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 1 1885

8. AGE:

Years	Months	Days	If less than one day
72			hrs. min.

9. Birthplace: Browns, Md. Pr. Geo. Co. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: at home

FATHER

12. Name: Benj. H. Brown

13. Birthplace: Kent Island, Md.

MOTHER

14. Maiden name: Caroline Virginia Walters

15. Birthplace: Howard Co. Maryland

18. Informant: Lawrence L. Cobb.

Address: Upper Marlboro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 27, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cemetery

Location: Marlboro, Md.

18. Funeral director: J. Fillery Sasscer & Co.

Address: 300 - 4th St. N. E.

19. Aug 25 1947 (Date rec'd by registrar) Edna F. Collins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25 1947, at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 24 1947, to Aug 25 1947

and that I last saw h[illegible] alive on Aug 24 1947

	DURATION
Immediate cause of death: Acute Coronary Thrombosis	10 hrs
Due to: Generalized Arteriosclerosis	unknown
Due to: —	
Other conditions: none of note	—

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: — none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Bruce Van Natta M. D.

Address: Washington 9, D.C. Date signed: Aug 25 1947

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07253

170 C

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dead on arrival

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Landover Hills (If outside city or town limits, write RURAL and give nearest town)

Street No. 4212 - 71st Ave (If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Barton Guy Bryan

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Clara Bryan

6.(c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.): July 25, 1921

8. AGE: Years 26 Months Days If less than one day ... hrs. ... min.

9. Birthplace: Illinois (Town, county, and state)

10. Usual occupation: Credit Clerk

11. Industry or business

FATHER 12. Name: James Bryan

13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: Anna Gibson

15. Birthplace: Illinois

16. Informant: Van W. G. Bryan

Address: 4212-71st St, Landover Hills

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 5 1947 (month) (day) (year)

Cemetery or crematory: Arlington Cemetery

Location: Arlington Va

18. Funeral director: L. Gasch's sons

Address: Hyattsville Md.

19. Aug 3 1947 (Date rec'd by registrar) James Sevroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1 1947, at 3 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ......19...., to ......19.... and that I last saw h.... alive on ......19....

	DURATION
Immediate cause of death: Hemorrhage and shock	
Due to: Crushed chest Fractured skull	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings of operations: ... Date of op.	
Autopsy results:	

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 8-1-47

Where did injury occur: East Riverdale P. G. Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where): Public Place

Means of injury: Passenger in car that collided with fixed object

Deputy medical examiner

23. SIGNATURE: [illegible] M. D. or other

Address: Brentwood Date signed 8-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07254

170C

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince George's
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 Hours
Hospital, institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? 22 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Landover Hills
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4212 71st Place
(If rural, give LOCATION)
2.(a) If veteran, name war: World War # 2

3.(a) FULL NAME: Clara R. Bryan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Barton Guy Bryan
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): April 22, 1922

8. AGE:	Years	Months	Days	If less than one day
	25			hrs. min.

9. Birthplace: Aberdeen, South Dakota (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home
FATHER 12. Name: Engle E. Cline
13. Birthplace: Kentucky
MOTHER 14. Maiden name: Nora I. Ryan
15. Birthplace: Wisconsin
16. Informant: Van W. G. Bryan
Address: 4212 71st Place, Landover Hills, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 5 1947 (month) (day) (year)
Cemetery or crematory: Arlington Cemetery
Location: Arlington Va.
18. Funeral director: F Gaschs Sons
Address: Hyattsville Md
19. Aug 5 1947 (Date rec'd by registrar) James Geary Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2 19 47 at 2:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Intra cranial hemorrhage	
fracture of the skull	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 8/1/47
Where did injury occur? E. Riverdale (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Finns Lane
Means of injury: Passenger in car that ran off Road Injured at work?

23. SIGNATURE: James J. [illegible] Deputy Medical Examiner M. D. or Coroner
Address: Forestville, Md. Date signed: 8/2/47

67255

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 345

1. PLACE OF DEATH:
County: Prince George's
City or town: Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 hrs. 35 min.
Hospital, institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? 29 hrs. 35 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County: Blair
City or town: Altoona
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2220 22d Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mrs. Carrie Carnell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: George J. Carnell
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept-23-1873

8. AGE: Years 73 | Months 11 | Days 17 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Altoona, Blair Co. Pa.
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER
12. Name: George Jackson
13. Birthplace: Blair Co. Pa.

MOTHER
14. Maiden name: Emma Bowser
15. Birthplace: Blair Co. Pa.

16. Informant: Donald J. Hertz (son in law)
Address: 4030 Hamilton St. Hyattsville, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Aug. 13th 1947 (month) (day) (year)
Cemetery or crematory: Oak Ridge Cemetery
Location: Altoona, Pa.

18. Funeral director: Geo. W. Wise Co. Inc.
Address: 2900 M St. N.W.

19. Aug. 10th 1947 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 16 1947, at 1:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 6 1947 to Aug 10 1947 and that I last saw h[illegible] alive on Aug 9. 1947.

Immediate cause of death	DURATION
Coronary Occl Head of Pancreas with Jaundice	1 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Not Done. Date of op.

Autopsy results: Not Done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

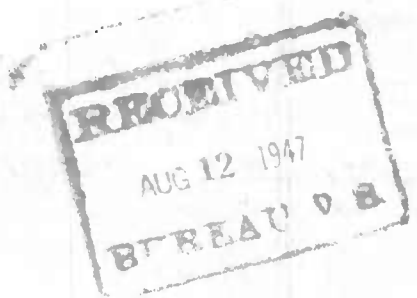
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L W Malin M.D.
M. D. or other
Address: Riverdale, Md. Date signed: 8-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
AUG 12 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67256

130

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 hours, 45 minutes

Hospital, institution, or street address where death occurred:
Prince George General Hospital

How long in hospital or institution? 10 hours, 45 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Catterton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 9th, 1947

8. AGE: Years	Months	Days	If less than one day
		4	hrs. min.

9. Birthplace: Upper Marlboro, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Catterton, James H.

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Grison, Ida Mae

MOTHER 15. Birthplace: Maryland

16. Informant: Father, James Catterton

Address: Upper Marlboro, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-14-47 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Md

Location: Blandensburg Md

18. Funeral director: Pitchit Bros

Address: Upper Marlboro Md

19. 8/13/47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13th 19 47 at 1:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Aug 47 19 to 13 Aug 19 47

and that I last saw him alive on 13 Aug 47 19

Immediate cause of death	Acute Hepatitis	DURATION
Due to	Cause Undetermined	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R B Lasseter M. D. or

Address: Upper Marlboro, Md Date signed: 13 Aug 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

67257

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges Co.
City or town Kenilworth Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prs Geo Co,
City or town Kenilworth Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5012 Quarles St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sallie A. Clark

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife F. E. A Clark
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Feb 17, 1870

8. AGE: Years 77 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business

FATHER
12. Name Thomas Draper
13. Birthplace North Carolina

MOTHER
14. Maiden name Maggie Smith
15. Birthplace North Carolina

16. Informant Miss Corrine Clark
Address Kenilworth Md

17. Burial, cremation, or removal. Which? transportation Date thereof Aug 18. 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Jernigan Cemetery
Location Morristown Tenn

18. Funeral director F Gaeche Sons
Address Hyattsville Md.

19. 8/18/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1947, at 12 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944, to Aug 17 1947 and that I last saw her alive on Aug 13 1947

Immediate cause of death	DURATION
Cardio vascular Renal Disease	1 yr
Due to	
Due to	
Other conditions Multiple Carbuncles	4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... injured at work?

23. SIGNATURE John D. Malony M.D.
M. D. or other
Address Cheverly Md Date signed 8-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67258

457

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 159 days
Hospital, institution, or street address where death occurred: Eugene Leland Memorial Hospital
How long in hospital or institution? 159 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Bladensville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Marrow Guy Collins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 17 - 1881

8. AGE: Years	Months	Days	If less than one day
66	7		hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Beaver, Tavern Owner

11. Industry or business: Owns a Tavern

FATHER
12. Name: Thomas Pennington Collins
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary Jane Linton
15. Birthplace: Md.

16. Informant: From the information on the Chart
Address: given us by Mr Collins himself

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 20 1947 (month) (day) (year)

Cemetery or crematory: St. Johns Cemetery
Location: Beltsville, Md.

18. Funeral director: W W Chambers Co.
Address: Riverdale, Md.

19. August 18 1947 (Date rec'd by registrar)
Mrs. Jay Severe
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 17, 1947, at 6 43 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 1946, to Aug 17. 1947
and that I last saw him alive on Aug 16 1947

Immediate cause of death: Carcinoma Stomach. — DURATION: 10 mo

Due to: & Cancrum. —

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. B. [illegible] M. D. or other
Address: Laurel Md Date signed

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67259

157a

Reg. Diat. No. 242

1. PLACE OF DEATH:

County: Prince George's

City or town: Capital Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred:
Dead on arrival at Dr. Brainins Office

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Hillside
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4905 L Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Esther Conte

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 5, 1947

8. AGE: Years | Months: 1 | Days: 21 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Anthony Conte
13. Birthplace: Italy

MOTHER
14. Maiden name: Esther Procopio
15. Birthplace: Italy

16. Informant: Anthony Conte
Address: Hillside, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-28-47 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Md.

18. Funeral director: W. W. Chambers Co.
Address: 517 11th St. S.E.

19. Aug. 27 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 1947, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Coronary heart disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Deputy Medical Examiner James S. Bond M. D. or other

Address: Forestville, Md. Date signed 8/26/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully (no correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

67260

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170C

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Permanent

Hospital, Institution, or street address where death occurred: Headon Arrival Leland Memorial Hosp

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Texas County Clay

City or town Petrolia

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war V

3. (a) FULL NAME Fay Cooper

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 30. 1919

8. AGE: Years	Months	Days	If less than one day
28			..... hrs. ..... min.

9. Birthplace Byers Texas (Town, county, and state)

10. Usual occupation School Teacher

11. Industry or business Public School.

FATHER 12. Name David W. Cooper

13. Birthplace Alvord Texas

MOTHER 14. Maiden name Marie A Farmer

15. Birthplace Caldwell Texas

16. Informant David W. Cooper

Address Wichita Falls Texas

17. Transportation (Burial, cremation, or removal. Which?) Date thereof Aug 27, 1947 (month) (day) (year)

Cemetery or crematory Hawkins Funeral Home

Location Henrietta, Texas

18. Funeral director F. Gaschis Sons

Address Mt Rainier, Md.

19. Aug 27 1947 (Date rec'd by registrar) Mrs Jas Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1947, at 1 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

aed that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and Shock	
Due to Crushed Pelvis and Crushed Chest	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8-26-47

Where did injury occur? Bellevue (City or town) Cass (County) Texas (State)

Injured at home, farm, industry, public place (where?) Route #1

Manner of injury Passenger in car injured in collision with two people

23. SIGNATURE ..... M. D. or Other

Address Riverdale Md Date signed 8-26-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67261

486

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George
City or town: Bowie Road Laurel R. F. D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince George
City or town: Laurel R. F. D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Myrtle P. Dare

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife: Martin Dare
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Feb 27, 1898

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
49	5	8		

9. Birthplace: Howard Co Md (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business
FATHER 12. Name: John Gover
13. Birthplace: Md Howard Co
MOTHER 14. Maiden name: Catherine Gover
15. Birthplace: Md Howard Co.
16. Informant: Martin Dare
Address: Bowie Road Laurel R. F. D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 6 1947 (month) (day) (year)
Cemetery or crematory: Providence
Location: Howard Co near Glenile Md
18. Funeral director: Ridgely Selby
Address: 401 Woodbine Laurel Md
19. Aug. 6 1947 (Date rec'd by registrar) Mrs J W Yingling Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 4 1947, at 5 45 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
2 4 1946 to 8 4 1947
and that I last saw her alive on 8 3 1947

	DURATION
Immediate cause of death: Acute Cardiac Dilatation	1d
Due to: Gen. Carcenomatosis	1 yr
Due to: Cancer Uterus	15 mo
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Gen. Carcenomatosis Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B R Warren M.D. M. D. or other
Address: Laurel Md Date signed: 8 5 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67262

516

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince George

City or town: Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6317 Central Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: John William Dedman.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Jane Dedman

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Nov 11. 1879

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
67				

9. Birthplace: England (Town, county, and state)

10. Usual occupation: Retired Carpenter

11. Industry or business: U.S. Capitol

FATHER — 12. Name: Frederick Dedman

FATHER — 13. Birthplace: England

MOTHER — 14. Maiden name: Henrietta Price

MOTHER — 15. Birthplace: England

16. Informant: Mrs. Jane Dedman

Address: 6317 Central Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 14 1947 (month) (day) (year)

Cemetery or crematory: Washington Nat Cemetery

Location: Suitland, Md.

18. Funeral director: J. William Lee & Son

Address: 300 - 4th St N.E. Wash. DC

19. Aug 13 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 12 1947 at 7 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 1947 to Aug. 12 1947 and that I last saw him alive on August 12 1947.

	DURATION
Immediate cause of death: Carcinoma of Prostate with metastases	2 years.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: William Brannan M. D. or other

Address: Capitol Hgts, Md. Date signed: 8/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67263

932

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Prince George's General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Edmonston
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5006-47th Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Dorsey, James A.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife: GEORGIA S DORSEY

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 4th, 1873

8. AGE: Years	Months	Days	If less than one day
74	7	4	..... hrs. ..... min.

9. Birthplace: Kentucky
(Town, county, and state)

10. Usual occupation: Clerk - Retired

11. Industry or business: U.S. Government

FATHER
12. Name: Not known
13. Birthplace: Ireland

MOTHER
14. Maiden name: Not Known
15. Birthplace: Ireland

16. Informant: Mrs. Georgia S. Dorsey

Address: 5006 47th. Ave, Edmonston, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 11 1947 (month) (day) (year)

Cemetery or crematory: Congressional

Location: Washington D.C.

18. Funeral director: W. W. Chambers Co.

Address: Riverdale, Md.

19. Aug 8 1947 (Date rec'd by registrar) Amanda L. Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 1947, at 7 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1947, to Aug 8 1947 and that I last saw him alive on August 7 1947

Immediate cause of death	DURATION
Congestive heart failure	3 wks
Due to Arteriosclerotic heart disease	Unknown
Due to	
Other conditions Marasmus, moderate	2 wks.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Julius Kaufman, M.D. M. D. or other

Address: 5423 Franklin Road, Bladensburg, Md. Date signed: 8/8/47

VS/A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d

67264

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Bowie Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Bowie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Katie Duckett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	widowed.

6.(b) Name of husband or wife: Daniel Duckett

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 25 1881

8. AGE:

Years	Months	Days	If less than one day
66	5	27	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: home work

11. Industry or business

FATHER

12. Name: Thomas William

13. Birthplace: Maryland

MOTHER

14. Maiden name: dont know

15. Birthplace: Maryland

16. Informant: Lawrence Snowden

Address: Bowie Md.

17. buried (Burial, cremation, or removal. Which?) Date thereof aug 26 1947 (month) (day) (year)

Cemetery or crematory: Brooklyn

Location: Glendale Md

18. Funeral director: Clarence Foreacre

Address: Mitchellville Md

19. August 24 1947 Mrs. J. W. Quigley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 22 1947, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 21 1947, to Aug 22 1947

and that I last saw h.er alive on Aug 21 1947

Immediate cause of death	DURATION
cardiac decompensation	2 hrs
Due to chronic rheumatic heart disease	unknown
Due to	
Other conditions bronchial asthma	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. M. Brady M.D. M. D. or other

Address: Beat Pleasant Md Date signed: Aug 23 1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67265

Reg. Dist. No. 27 239

1. PLACE OF DEATH:
County Prince Georges
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Unknown
Hospital, Institution, or street address where death occurred
Route #1 South of Laurel
How long in hospital or institution? 0

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Illinois County Kane
City or town Aurora
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D #3 Box 600
(If rural, give LOCATION)
2.(a) If veteran, name war World War II

3.(a) FULL NAME Robert L. Ebey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 1, 1922

8. AGE:

Years	Months	Days	If less than one day
24	11	1	..... hrs. ..... min.

9. Birthplace Aurora, Ill. (Town, county, and state)
10. Usual occupation Truck Driver
11. Industry or business U.S. Army

FATHER
12. Name Charles Ebey
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant U.S. Army Records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 6 47 (month) (day) (year)
Cemetery or crematory Aurora
Location Aurora, Ill.

18. Funeral director Eddy & Zuber, Inc.
Address 403 S. Wolfe St. Baltimore

19. 5 August 1947 (Date rec'd by registrar) MILLARD A. ALEA, CAPT., MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 19 47, at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Hemorrhage and shock	
Due to Compression of spinal cord & subarachnoid hemorrhage	
Due to Fracture dislocation of 1st cervical vertebra	
Other conditions Compound fracture left tibia and fibula, laceration of head	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results Confirms above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 8-2-47
Where did injury occur? Laurel (City or town) P.G. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Rt #1
Means of injury Pedestrian struck Injured at Work
Deputy medical Examiner
23. SIGNATURE ..... M. D. or other
Address Forestville Md. Date signed 8-2-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Run to R.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

67266

13 1a

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince Georges
City or town Clinton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
Pine View Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Prince Georges
City or town Clinton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Pine View Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Edward Everett England

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widowed

6.(b) Name of husband or wife Lydia H. England
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 23, 1860

8. AGE: Years 87 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Merchant Miller
11. Industry or business Flour Mills

FATHER
12. Name Robert Hayes England
13. Birthplace Maryland

MOTHER
14. Maiden name Sarah Newton
15. Birthplace Maryland

16. Informant Edwin R. England
Address Clinton, Md.

17. Burial Date thereof 8-30-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mitchells Presbyterian
Location Mitchell, Md.

18. Funeral director C. M. Chambers Co.
Address 517 11th St. S.E.

19. Aug. 29 1947 Carrie F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1947 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Acute congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Deputy medical Examiner
M. D. or other
Address Forestville Md. Date signed 9-27-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1226

CERTIFICATE OF DEATH

67267

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct as is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 hrs. and 20 min.
Hospital, institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution? 31 hrs. and 20 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4003 Jefferson St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: GWENDOLYN FERRIS

3.(b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 4, 1929

8. AGE: Years: 18 Months: 6 Days: 6 If less than one day: hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Laurance Ferris
13. Birthplace: New York

MOTHER
14. Maiden name: Marian Underwood
15. Birthplace: California

16. Informant: Mrs. Marian Ferris
Address: 4003 Jefferson St., Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 (month) 13 (day) 47 (year)
Cemetery or crematory: Washington National
Location: Suitland, Md.

18. Funeral director: A. A. Chambers
Address: 5801 Cleveland Ave. Riverdale, Md.

19. 8/12 19 47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10, 1947 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 7 1947 to Aug 10 1947 and that I last saw her alive on Aug 10 1947

	DURATION
Immediate cause of death: Intestinal obstruction	
Due to: Acute serofibrinopurulent peritonitis & volvulus	6 hrs
Due to: Ruptured congenital patulous uracus	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. L. Ehrman M. D. or other
Address: Riverdale, Md. Date signed: 8-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136 — 17268

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 11 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 month, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1106 - 6th St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: LOUISE C. GIBSON

3.(b) Social Security Number: 579-34-5040

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 20, 1923

8. AGE: Years	Months	Days	If less than one day
23	10	0	hrs. min.

9. Birthplace: Bristerburg, Virginia
(Town, county, and state)

10. Usual occupation: Maid

11. Industry or business: —

FATHER — 12. Name: John Thomas Gibson

13. Birthplace: Bristerburg, Virginia

MOTHER — 14. Maiden name: Maggie Blackwell

15. Birthplace: Bristerburg, Virginia

16. Informant: Deceased

Address:

17. (Burial, cremation, or removal. Which?) removal — Date thereof: 8/20/47 (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: F. E. Murray

Address: 1337 - 10th St. N.W. D.C.

19. (Date rec'd by registrar) 8/20/47 — Roland S. Phillips, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20th 1947 at 8 05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8th 1947, to Aug 20th 1947 and that I last saw her alive on Aug 20th 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	1 yr. 2 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Finucane M.D. (M. D. or other)

Address: Glenn Dale Md. Date signed:

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

67269

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges

City or town Cedar Heights (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 months

Hospital, institution, or street address where death occurred:

6415- Sheriff Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Cedar Heights (If outside city or town limits, write RURAL and give nearest town)

Street No. 6415 - Sheriff Road (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Willie Gilchrist

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Married

6.(b) Name of husband or wife Eliza Gilchrist

6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Oct 17, 1886

8. AGE:

Years	Months	Days	If less than one day
60			hrs. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name William Gilchrist

FATHER 13. Birthplace North Carolina

MOTHER 14. Maiden name Laura B. Gilchrist

MOTHER 15. Birthplace North Carolina

16. Informant Spencer Gilchrist

Address 6415 - Sheriff Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Paynes

Location Benn - Road S.E. Wash D.C.

18. Funeral director L.E. Murray & Son

Address 1337-10th St. N.W. Wash D.C.

19. Aug-15-1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1947, at 6 00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive Heart Failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Report Medical Examiner M. D. or other

Address Date signed 8-12-47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

67270
234
Reg. Dist. No. 4

1. PLACE OF DEATH:
County PRINCE GEORGE
City or town (RURAL) OXEN HILL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County PRINCE GEORGE
City or town (RURAL) OXEN HILL
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME HENSON OLLIE HALL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	WIDOWED

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
72 ?			hrs. min.

9. Birthplace Prince George Co. Md. (Town, county, and state)
10. Usual occupation GARDENER
11. Industry or business
FATHER 12. Name UNKNOWN
13. Birthplace
MOTHER 14. Maiden name UNKNOWN
15. Birthplace
16. Informant MABEL HALL (DAUGHTER)
Address 4534 WHEELER ROAD, PR+ GEO. MD.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof AUG. 5, 1947 (month) (day) (year)
Cemetery or crematory ST. PAUL M.E. CHURCH CEMETERY
Location OXEN HILL
18. Funeral director Robert G. Mason
Address 2500 Nichols Ave. SE, Wash. D.C.
19. Sept 7 1947 Howard J. Beall (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1947, at 11:15 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 18 1947, to August 1 1947
and that I last saw him alive on August 1 1947
Immediate cause of death Cardiac Dilatation — DURATION 14 days
Due to Cardio-Vascular-Renal Disease — 7 months
Due to
Other conditions Chronic Bronchitis and Arterio-Sclerosis
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Luther J. Scott M. D. or other
Address 2504 Nichols Ave SE Date signed 8.2.47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

836

07271

CERTIFICATE OF DEATH

Reg. Dist. No. 231

M.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Prince George County

City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 51 days

Hospital, institution, or street address where death occurred:
Prince George Hospital

How long in hospital or institution? 51 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3724-35th Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Hanback, Mrs. Ida

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 22nd, 1874

8. AGE: Years	Months	Days	If less than one day
73	7	2	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Retired Govt. Employee

11. Industry or business:

FATHER
12. Name: John Schuh
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: Elizabeth Miller
15. Birthplace: Washington, D.C.

16. Informant: Sister, Maude Werner
Address: 3724-35th Str. Mt. Rainier

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 26, 1947 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: 3201- Bladensburg Rd. Edmar Manor

18. Funeral director: Wm. J. Malloy

Address: 3200 - R. I. Ave. Mt. Rainier, Md.

19. 8/25 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24th 1947, at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Aug 1947 to 24 Aug 1947 and that I last saw h alive on 23 Aug 1947

Immediate cause of death	DURATION
Hypostatic Pulmonary Congestion	2 days
Due to: Cerebral Embolus	1 Month
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: No Operation

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. L. Eberenz M. D. or other

Address: Kenilworth, Md. Date signed: 8-24-47

4309 Farragut

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67272

164e

Reg. Dist. No. 231

M

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days, 8 hrs. 50 min.

Hospital, institution, or street address where death occurred:
Prince George's General Hospital

How long in hospital or institution? 5 days, 8 hrs. 50 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5703-39th Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

~~MARIAN HANKEY~~ MARION M. HANKEY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 3, 1905

8. AGE: Years	Months	Days	If less than one day
42	2	12	hrs. min.

9. Birthplace: Michigan
(Town, county, and state)

10. Usual occupation: Secretary

11. Industry or business

FATHER
12. Name: William Hankey
13. Birthplace: Michigan

MOTHER
14. Maiden name: Amanda ~~Howen~~ Moen
15. Birthplace: Michigan

16. Informant: Self

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-19-1947 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Rockville, Montg. Co. Md.

18. Funeral director: Adams E. Pumphrey

Address: Silver Spring, Md.

19. Aug. 16" 1947 (Date rec'd by registrar) Mona Lee Reverse Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15, 1947 at 6:20P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Peritonitis,	
Intra abdominal hemorrhage	
Due to Crushed abdomen	
Due to	
Other conditions Fracture of right femur	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 8-11-47

Where did injury occur? Hyattsville (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Hyattsville Md.

Means of injury: Automobile Injured at work?

Nature of injury: Multiple Internal Injuries

23. SIGNATURE: James E. Pumphrey M. D. or Coroner

Address: Hyattsville Md. Date signed 8-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67273

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs., 12 mos., 29 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 14 years, 12 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1209 Oates St., N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: EDWARD HARRIS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Lillian Harris
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 16, 1890

8. AGE: Years	Months	Days	If less than one day
57 57	0	5	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business: -

FATHER
12. Name: John Harris
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Carter
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Burial, cremation, or removal. Which?: Removal
Date thereof: Aug 21/47 (month) (day) (year)
Cemetery or crematory:
Location: Washington DC
18. Funeral director: Ambrose B. Boyd
Address: 1238-20th St N. W.

19. (Date rec'd by registrar) Aug 21 1947 Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 21 1947, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 23 1932, to Aug. 21 1947
and that I last saw h. l. m. alive on Aug 21 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	16 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale Md. Date signed: 8-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136 67274

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 9 - 4th St., S. E. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HARRIS, MARGARET MASON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edward T. Harris

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): May 18, 1893

8. AGE: Years	Months	Days	If less than one day
54	2	16	hrs. min.

9. Birthplace: Stafford, Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: -

FATHER 12. Name: George T. Armstrong

FATHER 13. Birthplace: Stafford, Virginia

MOTHER 14. Maiden name: Mary Smith

MOTHER 15. Birthplace: Stafford, Virginia

18. Informant: Deceased

Address

17. Removal - (Burial, cremation, or removal. Which?) Date thereof: Aug 4/47 (month) (day) (year)

Cemetery or crematory

Location: Washington, D.C.

18. Funeral director: J. Wm Lee's Sons

Address: 300-4th St N.E.

19. Aug 4, 1947 (Date rec'd by registrary) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 4 1947 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/10 1947 to 8/4 1947

and that I last saw h[illegible] alive on 8/4 1947

Immediate cause of death	DURATION
pulm. tuberculosis	19 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: 8/4/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67275

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mos., 1 day

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 8 mos., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 212 K. St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MAVIS ALYCE HARRIS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 16, 1929

8. AGE: Years	Months	Days	If less than one day
18	6	2	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: –

FATHER
12. Name: Louis Harris
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Lillian Jones
15. Birthplace: Washington, D. C.

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 19-1947 (month) (day) (year)

Cemetery or crematory

Location: To Wash-D.C.

18. Funeral director: John T. Rhines + Co

Address: 901. 3rd-St. S.W.

19. (Date rec'd by registrar) 18 Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUG. 18 1947 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DEC. 16 1946 to AUG. 18 1947 and that I last saw h.. alive on AUG 18 1947

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	Yrs 1 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 8/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

M

67276

170C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Prince Georges County
City or town Cheverly Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Prince Georges Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Pro Geo County
City or town Maryland Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 65th & C Sts.
(If rural, give LOCATION)
2.(a) If veteran, name war none

3.(a) FULL NAME Edward Hale Hayes

3.(b) Social Security Number

4. Sex male
5. Color or race white
6.(a) Single, married, widowed, or divorced single
6.(b) Name of husband or wife --
6.(c) If alive, give age -- years
7. Birth date of deceased (mo., day, yr.) July 27, 1879-
8. AGE: Years 68 Months Days If less than one day ... hrs. ... min.
9. Birthplace Washington D. C.
(Town, county, and state)
10. Usual occupation General laborer
11. Industry or business

FATHER
12. Name Edward Hayes
13. Birthplace Ireland

MOTHER
14. Maiden name Gertrude Tune
15. Birthplace Washington D. C.

16. Informant Mrs Ida Quinn
Address 1021 Girard St N E Washington D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 2, 1947- (month) (day) (year)
Cemetery or crematory Mt Olivet Cemetery
Location Washington D. C.
18. Funeral director F. Gasch's Sons
F. Gasch's sons
Address Hyattsville Maryland.
19. 9/1 19 47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1947 at 10:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death Shock
Due to Intra cranial hemorrhage
Due to Fracture of skull
DURATION

Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 8-30-47
Where did injury occur? Seat Pleasant P. G. Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Addison Road
Means of injury Pedestrian struck by car Injured at work
Deputy medical examiner

23. SIGNATURE [illegible] M. D. or other
Address Hyattsville Md Date signed 8-31-47

VS A15 9-45-15M

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07277

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 635 South Carolina Ave., S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: CHARLES HENSON

3. (b) Social Security Number: 577-22-7106

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 20, 1895

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
52	7	9		

9. Birthplace: Misserville, Maryland
(Town, county, and state)

10. Usual occupation: Porter

11. Industry or business: –

FATHER
12. Name: Charles Henson
13. Birthplace: Misserville, Maryland

MOTHER
14. Maiden name: Ellen Vale
15. Birthplace: Misserville, Maryland

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 1 47 (month) (day) (year)

Cemetery or crematory: Arlington Cemetery

Location: Arlington. Va.

18. Funeral director: H. Ernest Davis Co.

Address: 1432 - You St. N.W.

19. Aug. 29 47 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUG. 29 1947 at 8:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUG. 15 1947 to AUG. 29 1947 and that I last saw him alive on AUG. 29 1947

Immediate cause of death	DURATION
Neoplasm of left face and neck type undetermined	1 yr.
Due to: Pulmonary Tuberculosis	2 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 8-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67278

186a

Reg. Dist. No. 765

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: Leland Memorial
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9112 Baltimore Blvd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Clifton Varner Houlehan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 30, 1917

8. AGE: Years 30 | Months 4 | Days 25 | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Charles Pinkney Houlehan
13. Birthplace: Virginia

MOTHER
14. Maiden name: Rita Margaret Varner
15. Birthplace: Virginia

16. Informant: Charles P. Houlehan
Address: 9112 Baltimore Blvd, Riverdale

17. Disposition: transportation Date thereof: Aug 26, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Catholic Cemetery
Location: Mustoe Va.

18. Funeral director: F. Gasch's sons
Address: Hyattsville Md.

19. Aug 26 1947 Mrs. Jos. Devere Deputy Registrar
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 25 1947 at 5:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Internal Cranial hemorrhage	
Due to: Fracture of skull	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results: Given above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 8-21-47
Where did injury occur? Riverdale (City or town) Pr. Geo. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Fell down steps Injured at work?

23. SIGNATURE: Deputy medical Examiner M. D. or other
Address: Hyattsville Md. Date signed: 8-26-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH PERMANENT FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 b

67279

Reg. Diat. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos., 10 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 6 mos., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 321 Virginia Avenue, S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WALTER HUDSON

3.(b) Social Security Number: 578-16-1591

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Helen Hudson
6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): July 12, 1909

8. AGE: Years	Months	Days	If less than one day
38	1	1	hrs. min.

9. Birthplace: Charlotte, North Carolina
(Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business: -

FATHER
12. Name: John Hudson
13. Birthplace: Charlotte, North Carolina

MOTHER
14. Maiden name: Mary Carr
15. Birthplace: Charlotte, North Carolina

16. Informant: Deceased
Address

17. removal; Date thereof: Aug 14 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Washington
Location: D.C.
18. Funeral director: Malcuan & Sehey
Address: 424 R St. N.W., Wash. D.C.

19. Aug 14 1947 Rowland S. Philp, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUG. 13 1947 at 7:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 3 1947, to Aug. 13 1947
and that I last saw h.. alive on Aug. 13 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr. 5 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glen Dale, Md. Date signed: 8-13-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67280

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 2 mos., 29 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 2 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1235 Delaware Avenue, S. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME FRANK T. JACOBS, JR.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 17, 1928

8. AGE: Years	Months	Days	If less than one day
18 18	0	11	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: -

11. Industry or business: -

FATHER
12. Name: Frank Jacobs
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Leona Wright
15. Birthplace: North Carolina

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof aug 29/47 (month) (day) (year)

Cemetery or crematory:

Location: Washington D. C.

18. Funeral director: Rev. L. B. Hanson, P.E.R. B.F.T.

Address: 306 2nd St. N.W. Washington D.C.

19. Aug. 28, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 28th 1947 at 10:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29th 1946 to Aug. 28th 1947 and that I last saw him alive on Aug. 28th 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 1 yr. 3 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed 8/28/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

07281

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince George's
City or town Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years. 28 days.
Hospital, Institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? 2 years. 28 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ..... County .....
City or town .....
(If outside city or town limits, write RURAL and give nearest town)
Street No. ..... Welfare
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Mr. William Carrol Jamieson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Sally Elizabeth
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 4-1861

8. AGE: Years 85 | Months 8 | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual occupation R.R. Tee - Retired
11. Industry or business Carpet layer

FATHER
12. Name Calhill Jamieson
13. Birthplace —

MOTHER
14. Maiden name .....
15. Birthplace —

16. Informant Leland Memorial Hospital Records
Address Riverdale, Md.

17. Cremated (Burial, cremation, or removal? Which?) Date thereof 8/4/1947 (month) (day) (year)
Cemetery or crematory Arthur Walters Funeral Home
Location Takoma Park, D.C.

18. Funeral director Arthur Walters By Hmdy
Address 254 Carroll St. N.W. Takoma Park D.C.

19. 8/2 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 2 1947 at 12½ - M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1945 to Aug 2 1945; and that I last saw him alive on Aug 1 1945.

Immediate cause of death	DURATION
General arteriosclerosis with Senility	10 yrs.
Due to	
Due to	
Other conditions Spontaneous fractures of both hips	8 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE L. W. Malin M.D.
M. D. or other
Address ..... Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

Home for Aged, Rockville

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

67282

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince Georges
City or town Cedar Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred:
1120-65th Avenue
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Cedar Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1120-65 Ave
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Johnson, Thomas

3.(b) Social Security Number not known

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ? 1887

8. AGE: Years	Months	Days	If less than one day
60+			hrs. min.

9. Birthplace Fredericksburg, Va (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Varied

FATHER 12. Name unknown

13. Birthplace "

MOTHER 14. Maiden name unknown

15. Birthplace "

16. Informant Tyler, Elizabeth

Address 618-O St N.W., D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8-12-1947 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director Henry S. Washington & Son

Address 467 N. St. Washington D.C.

19. Aug 12 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1947, at 11:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12 1947 to Aug 12 1947 and that I last saw h... alive on August 12 1947

	DURATION
Immediate cause of death Myocardial decompensation	3 weeks
Due to Coronary thrombosis	3 weeks
Due to Arteriosclerosis	?
Other conditions cerebral atrophy	1 yr
Cause undetermined	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Theodore Pinckney M.D.
M. D. or other

Address 4832 Deane Ave NE Washington D.C. Date signed 8/12/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH INDELIBLE FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67283

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Fairmount Heights (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. (Suitland)
Hospital, Institution, or street address where death occurred: 5807 Sheriff Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)
State: Maryland County: Prince Georges
City or town: Fairmount Heights (If outside city or town limits, write RURAL and give nearest town)
Street No. 5807 Sheriff Rd. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Henry Kelliebrew

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mrs. Odie Kelliebrew
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): August 2, 1887

8. AGE: Years	Months	Days	If less than one day
60	0	21	hrs. min.

9. Birthplace: Edgecombe County, N. C. (Town, county, and state)
10. Usual occupation: Minister
11. Industry or business
12. FATHER — Name: Dennis Kelliebrew
13. FATHER — Birthplace
14. MOTHER — Maiden name: /
15. MOTHER — Birthplace
16. Informant: Mr. Samuel Kelliebrew
Address: 5807 Sheriff Rd.
17. Removal (Burial, cremation, or removal. Which?) Date thereof Aug. 23, 1947 (month) (day) (year)
Cemetery or crematory
Location: Washington DC
18. Funeral director: Alexander L. Pope
Address: 315-15 St NE
19. Aug. 23 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23 1947, at 2:40 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1947 to Aug. 23 1947
and that I last saw h... alive on Aug. 22 1947

Immediate cause of death	DURATION
Bilateral Expudative Pulmonary Tuberculosis	about 1 yr.
Due to: with Laryngitis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 1001 Eastern Ave. NE Date signed: 8/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07284

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs., 4 mos., 18 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 5 yrs., 4 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3419 - 22nd St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: WILLIAM KERFOOT

3.(b) Social Security Number: 578-16-4390

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anne C. Kerfoot

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): May 23, 1876

8. AGE: Years	Months	Days	If less than one day
71 71	3	7	....hrs. ....min.

9. Birthplace: Clark Co., Virginia
(Town, county, and state)

10. Usual occupation: Pharmiacist

11. Industry or business: -

FATHER
12. Name: Wm. L. Kerfoot
13. Birthplace: Virginia

MOTHER
14. Maiden name: Ella Chapin
15. Birthplace: Missouri

16. Informant: Deceased
Address

17. removal (Burial, cremation, or removal. Which?) Date thereof: Aug. 30, 1947 (month) (day) (year)

Cemetery or crematory: Washington, D.C.

Location

18. Funeral director: Frank Geier Sons Co.

Address: 3605 - 14th St. N.W. Washington, D.C.

19. Aug. 30, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 30 1947 at 12.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 11, 1942 to Aug. 30, 1947 and that I last saw him alive on Aug. 29, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? ....(City or town) ....(County) ....(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ....Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md., Date signed: 8/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

67285

Reg. Dist. No. 234

1. PLACE OF DEATH:
County: Prince George's
City or town: Camp Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
5704 Allentown Road
How long in hospital or institution? ...

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Camp Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5704 Allentown Road
(If rural, give LOCATION)
2.(a) If veteran, name war ...

3.(a) FULL NAME: Blanche Violet Kidwell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Albert Clinton Kidwell
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): June 13, 1901

8. AGE: Years: 46 | Months: | Days: | If less than one day: ...hrs. ...min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: ...

FATHER
12. Name: John Bitting
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Mary Kenepp
15. Birthplace: Pennsylvania

16. Informant: Albert Clinton Kidwell
Address: Camp Springs, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/30/47 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cem.
Location: Wash. D.C.

18. Funeral director: Woodward & Co.
Address: 577-11 St S.E.

19. Aug 28 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 28 19 47 at 12:30A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Deputy medical Examiner M.D. or other
Address: Forestville Md. Date signed 8-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157a

07286

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George.
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Yr.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Riverdale.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6102 - 44th Pl.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Richard Arthur La Belle.

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb. 11, 1945

8. AGE:

Years	Months	Days	If less than one day
2	5	24	hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: None
11. Industry or business: None.

FATHER
12. Name: Mederic La Belle
13. Birthplace: Canada

MOTHER
14. Maiden name: Rose Durette
15. Birthplace: Canada

16. Informant: Mederic La Belle
Address: 6102 - 44th Pl. Riverdale, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 7, 1947 (month) (day) (year)
Cemetery or crematory: Wash. National
Location: Dr. Sec. G. Md.
18. Funeral director: W. W. Chambers Co
Address: Riverdale, Md.
19. Aug. 5 1947 (Date rec'd by registrar) James Levy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 5, 1947 at 1 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 5, 1947 to Aug. 5, 1947
and that I last saw h— alive on — 19—

Immediate cause of death: Hydrocephalous — DURATION: 2 hrs.
Due to: —
Due to: —
Other conditions: —
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Walcutt W. Elson, M.D.
M. D. or other
Address: Riverdale, Md. Date signed: Aug. 5, 1947

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age shown on I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

07287

CERTIFICATE OF DEATH

Reg. Diat. No. 116

FILM No. G 112 SEP 3 1947

1. PLACE OF DEATH:

County Prince Georges

City or town College Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town College Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 110 Ivy Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Calvin Landon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Separated

6.(b) Name of husband or wife Helen B. Landon

6.(c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1906

8. AGE: Years	Months	Days	If less than one day
40	39	11	21 hrs. min.

9. Birthplace Laurel, Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Walter Landon

13. Birthplace Bladensburg, Md

MOTHER 14. Maiden name Mary E. Green

15. Birthplace Maryland

16. Informant Helen B. Landon

Address Berwyn, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 25, 1947 (month) (day) (year)

Cemetery or crematory Ivy Hill

Location Laurel Md

18. Funeral director F. Gaeke sons

Address Hyattsville Md

19. Aug 25 11 1947 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1947 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions Chronic Alcoholism	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner James J. Fox M. D. or Coroner

Address Hyattsville Md Date signed 8-23-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

67288

Reg. Dist. No. 7-34

1. PLACE OF DEATH:

County Prince George

City or town Washington 20, D.C.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Georges

City or town Silver Hill Road Suitland Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4461 Silver Hill Rd. S.E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Arthur Lawrence Latimer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Lillian A. Latimer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 13th, 1880

8. AGE: Years	Months	Days	If less than one day
66			..... hrs. ..... min.

9. Birthplace Suitland, Maryland (Town, county, and state)

10. Usual occupation Truck Farmer

11. Industry or business

FATHER 12. Name John W. Latimer

13. Birthplace Maryland

MOTHER 14. Maiden name Eliza A. Richardson

15. Birthplace Washington, D.C.

16. Informant Mrs. Lillian E. Wood

Address 4018-Branch Ave., S.E. Wash. 20 DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 8, 1947 (month) (day) (year)

Cemetery or crematory St. Barnabas Cemetery

Location Oxon Hill, Md.

16. Funeral director Arthur E. Simmons Jr

Address 3007 Nichols Ave S.E.

19. Aug 5 47 Howard I Beach Registrar

(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1947 at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 4 1947 to Aug 5 1947 and that I last saw him alive on Aug 4 1947

Immediate cause of death	DURATION
Acute Coronary Thrombosis	4 hrs
Due to Generalized Arteriosclerosis	Years
Due to and Mild acute bronchitis	5 Days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE Paul Lewis Watts M. D. or other

Address Washington 1925 Date signed Aug 5 1947

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07289

94a

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One hr. and 20 min.

Hospital, institution, or street address where death occurred:
Prince George's General Hospital

How long in hospital or institution? One hr. and 20 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3009 Central Ave., N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

MRS. STELLA K. LEWIS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 1, 1875

8. AGE: Years	Months	Days	If less than one day
72	9	10	hrs. min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Wm. Heltzel
13. Birthplace: Pa.

MOTHER
14. Maiden name: Sarah Wallower
15. Birthplace: Pa.

16. Informant: Helen S. Lewis
Address: Same

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/14/47 (Month) (day) (year)

Cemetery or Crematory: Forest Oak

Location: Gaithersburg, Md.

18. Funeral director: Robert J. Mattingly

Address: 1311 - 11th St. S.E. Washington

19. 8/12 1947 (Date rec'd by registrar) Amanda Devine Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11, 1947, at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 Aug 1947 to 11 Aug 1947 and that I last saw h[illegible] alive on 11 Aug 1947

Immediate cause of death	DURATION
Coronary Thrombosis	10 Hrs.
Due to Coronary Artery Disease	2 years
Due to Gen. arteriosclerosis	5 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Samuel J. Sugar M.D.
M. D. or other

Address: Mt Rainier, Md. Date signed: 11 Aug 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67290

13 L

Reg. Diat. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years, 7 mos., 10 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 3 years, 7 mos., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: 414 - R. St., N. W., Washington (If outside city or town limits, write RURAL and give nearest town)

Street No.: 414 - R. St., N. W. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: LYLES ERNEST

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6.(b) Name of husband or wife: Georgeanna Despera

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): September 4, 1876

8. AGE: Years	Months	Days	If less than one day
70	11	11	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business: -

FATHER 12. Name: Alfred Lyles

13. Birthplace: Prince Georges Co., Maryland

MOTHER 14. Maiden name: Minnie Whiting

15. Birthplace: Enricho Co., Virginia

16. Informant: Deceased

Address

17. Burial, cremation, or removal. Which?: Removal Date thereof: 8 (month) 15 (day) 47 (year)

Cemetery or crematory:

Location:

18. Funeral director: Robert F. McGuire

Address: 1820 - 9th St. N. W.

19. (Date rec'd by registrar) 19 Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 15 19 47 at 11 40 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/4 19 44 to 8/15 19 47

and that I last saw h. alive on 8/15 19 47

Immediate cause of death: pulm. Tuberculosis — DURATION: 4 yrs.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: 8/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

732

67291

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Pr. Geo.

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred: Pr. Geo. Hosp.

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Pr. Geo.

City or town: Tunneybrook

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Spring Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Manuel, Mrs. Mae

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M (D)

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 29 - 1895

8. AGE: Years: 52 | Months: 1 | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia (Town, county and state)

10. Usual occupation: H.W.

11. Industry or business:

FATHER — 12. Name: Hampton Baggerly

13. Birthplace: Va

MOTHER — 14. Maiden name: Martha Biggs

15. Birthplace: Va.

16. Informant: Mrs. Mattie D. George.

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 3, 1947 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: 3201- Bladensburg Rd. Md.

18. Funeral director: Wm. J. Nalley.

Address: 3200-R.I. Ave. Mt. Rainier, Md.

19. 9/2 (Date rec'd by registrar) 1947 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-31-47 1947 at 6 3/4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1947 to August 31 1947 and that I last saw her alive on August 30 1947

Immediate cause of death	DURATION
Lupus Erythematosis	6 or 7 mos.
Due to:	
Due to:	
Other conditions: General Debility and Anemia	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: D. S. Clayman M.D. M. D. or other

Address: Mt. Rainier, Md. Date signed: 8/31/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

67292

170d

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 hours

Hospital, institution, or street address where death occurred:

Eugene Leland Memorial Hospital

How long in hospital or institution? 31 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pri. Geo.

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3902 Jefferson st.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME CHARLES LEWIS MARTIN, JR.

3.(b) Social Security Number

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 17, 1931

8. AGE: Years 16 Months Days 20 If less than one day ... hrs. ... min.

9. Birthplace Washington, D.C.

(Town, county, and state)

10. Usual occupation Student

11. Industry or business Hyattsville High School

FATHER

12. Name Charles Lewis Martin

13. Birthplace Washington, D.C.

MOTHER

14. Maiden name Marian E. Cozlin

15. Birthplace Washington, D.C.

16. Informant Charles Lewis Martin

Address 3902 Jefferson st., Hyattsville, Md.

17. Burial Date thereof Aug 9, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Washington D. C.

F. Gasch's Sons

18. Funeral director F. Gasch's Sons

Address Hyattsville Maryland.

19. Aug. 9, 1947 Mrs. Jas. Severe Deputy Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1947, at 9:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Shock Cerebral Compression	
Due to Intra Cranial hemorrhage	
Due to Fracture of skull	

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8-6-47

Where did injury occur? Hyattsville P. G. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Street

Means of injury Rider of motor scooter - Collision

Deputy medical examiner

23. SIGNATURE [illegible] M. D. or other

Address Hyattsville Md. Date signed 8-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67293

96

Reg. Dist. No. 242

1. PLACE OF DEATH:
County PRINCE GEORGE
City or town COTTAGE CITY
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
3718-41st. Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Prince Geo
City or town Cottage City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3718 41 ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME
WILLIAM WALTON MASSENGILL

3.(b) Social Security Number
240-07-6278

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife Ruby A Massengill
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 31 1911

8. AGE: Years 35 | Months 9 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace No Car
(Town, county, and state)

10. Usual occupation Route Salesman

11. Industry or business Tent House Cleaners

MOTHER FATHER
12. Name Julius Massengill
13. Birthplace No Carr

MOTHER
14. Maiden name Annie Johnson
15. Birthplace No Car

16. Informant Ruby A Massengill
Address 3718-41 ave, Cottage City

17. Buried Date thereof Aug 6 47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Sardard No Car
Location
18. Funeral director H L Champion Co
Address 317-11 st S.E.

19. Aug 4 1947
(Date rec'd by registrar)
Carrie J Campbell
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1947 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
about 1943 to 8-2 1947
and that I last saw him alive on 8-2 1947

Immediate cause of death Cardiac Tamponade

Due to Dissecting aneurysm (Due to, or as a consequence of) (Interval between onset and death) 3 days

Essential Criteria Hypertension

Due to

Other conditions

DURATION

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Sylvan C Stevenson M. D. or other
Address 1711 Rhode Island Ave N.E. Date signed 8/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Additional information on cause of death obtained from report card in the Bureau of C. D. signed by Dr. Steiner.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

96

67294

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, Institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? 12 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1214 Shepherd St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Miss Catherine Gladys McKenna

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 22, 1899

8. AGE: Years	Months	Days	If less than one day
5.5	9	1	hrs. min.

9. Birthplace: Washington D.C
(Town, county, and state)
10. Usual occupation: Government Clerk
11. Industry or business:

FATHER
12. Name: Frank McKenna
13. Birthplace: Washington D.C.

MOTHER
14. Maiden name: Estelle Miller
15. Birthplace: Washington, D.C.

16. Informant: Anna Wells
Address: 1214 Shepherd St. N.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/27/1947 (month) (day) (year)
Cemetery or crematory: George Washington Memorial Park
Location: Prince Geo.

18. Funeral director: The S. H. Weiss Co.
Address: 2901-14th St. N.W. Wash. D.C.

19. 8/23 1947 (Date rec'd by registrar) Amanda Dorsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23 1947, at 5:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1939 to August 23 1947
and that I last saw h[illegible] alive on August 22 1947

	DURATION
Immediate cause of death: Ruptured Intracranial aneurysm	10 days
Due to: cerebral arteriosclerosis	uncertain
Due to: Hypertensive cardiac disease	
Other conditions: Ephasia from previous cerebral accident	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry J. Hadley M.D. M. D. or other
Address: 1252 16th St. Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67295

Reg. Diat. No. 239

1. PLACE OF DEATH:
County: PRINCE GEORGES
City or town: LAUREL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 YR'S
Hospital, institution, or street address where death occurred: 414 MAIN STREET
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: PRINCE GEORGES
City or town: LAUREL
(If outside city or town limits, write RURAL and give nearest town)
Street No. 414 MAIN STREET
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: WILLIAM ALBIN MILES JR.

3.(b) Social Security Number

4. Sex: MALE
5. Color or race: WHITE
6.(a) Single, married, widowed, or divorced: SINGLE
6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): MARCH 3, 1893
8. AGE: Years: 54 Months: 5 Days: 7 If less than one day: hrs. min.
9. Birthplace: LAUREL MARYLAND (Town, county, and state)
10. Usual occupation: STOREKEEPER
11. Industry or business

FATHER
12. Name: WILLIAM ALBIN MILES
13. Birthplace: LAUREL MARYLAND

MOTHER
14. Maiden name: CATHERINE VIRGINIA SWAPP
15. Birthplace: SILVER SPRING, MARYLAND

16. Informant: MRS. F. B. MAXWELL
Address: 414 MAIN St., LAUREL, Md.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof AUG. 12, 1947. (month) (day) (year)
Cemetery or crematory: IVY HILL CEMETERY
Location: LAUREL, MARYLAND
18. Funeral director: Arthur Phillips
Address: 505 WASHINGTON Blvd, LAUREL MD
19. 8-12 19 47 (Date rec'd by registrar) Cora E. Wachter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUGUST 10 1947 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCT-8 1946 to Aug 10 1947 and that I last saw him alive on Aug 9 1947

	DURATION
Immediate cause of death: Angina Pectoris	
Due to: Endocarditis, Myocarditis	8 M
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 311 P. St. Laurel Date signed 8/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

M

I

T

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

193

67296

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince Georges
City or town Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 7211-7 Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7215-7 St.
(If rural, give LOCATION)
2.(a) If veteran, name war World War II

3.(a) FULL NAME James Robert Moreland
3.(b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Irene Moreland
6.(c) If alive, give age 24 years
7. Birth date of deceased (mo., day, yr.) Oct 30, 1918
8. AGE: Years 28 Months Days If less than one day hrs. min.
9. Birthplace Croome, Md
(Town, county, and state)
10. Usual occupation Fireman
11. Industry or business Andrews Field
FATHER 12. Name Benjamin Moreland
13. Birthplace Maryland
MOTHER 14. Maiden name Annie Thomas
15. Birthplace Maryland
16. Informant Charles Moreland
Address 109-65th St, Washington D.C.
17. Burial Date thereof Aug 18, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Ft Lincoln
Location Washington D.C.
18. Funeral director F. Gasch's Sons
Address Hyattsville Md.
19. Aug. 14 1947 Carrie F. Campbell Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1947, at 11 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19...., to .... 19....
and that I last saw h.... alive on .... 19....

Immediate cause of death	DURATION
Shock	
Due to Electrocution	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 8-14-47
Where did injury occur Seat Pleasant P.G. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Injured at work?
Means of injury ... [illegible]
Deputy Medical Examiner
23. SIGNATURE [illegible] Boyd M. D. or other
Address Forestville [illegible] Date signed 8-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

67297

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince George

City or town Laurel (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince George

City or town Laurel (If outside city or town limits, write RURAL and give nearest town)

Street No. 315 Washington Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Wilmer Samson Musgrave

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Anne Sightler Musgrave

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 25, 1868

8. AGE: Years 79 Months Days 18 If less than one day ... hrs. ... min.

9. Birthplace Oyohee County Idaho (Town, county, and state)

10. Usual occupation Practice of Law

11. Industry or business General Law

FATHER 12. Name William Le Baron Musgrave

13. Birthplace Philadelphia Penna

MOTHER 14. Maiden name Anne Virginia Bard

15. Birthplace Virginia

16. Informant Mrs G. W. S. Musgrave

Address 315 Washington Ave Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 14, 1947 (month) (day) (year)

Cemetery or crematory Green Mount

Location Baltimore Md

18. Funeral director Ridgley Selby

Address 401 Wash Ave Laurel Md

19. Aug 13 1947 M. Brashears (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1947 at 6:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1 1930, to Aug 12 1947

and that I last saw him alive on Aug 12 1947

	DURATION
Immediate cause of death: Chronic Myocarditis	5 years
Due to	
Due to	
Other conditions: Parkinsons Disease	11 years

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE Robert S McCeney M.D. (M.D. or other)

Address 402 Main St Laurel Md Date signed 8/12/47

67298

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince George County
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days 16 hrs. 45 Minutes
Hospital, institution, or street address where death occurred:
Prince George General Hosp.
How long in hospital or institution? 2 Days 16 Hrs. 45 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Suitland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4710 Park Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Naecker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ruth Naecker
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 25 1890

8. AGE:	Years	Months	Days	If less than one day
	57	4	30	hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: mechanic

11. Industry or business:

FATHER
12. Name: Louis Naecer
13. Birthplace: Germany

MOTHER
14. Maiden name: Sophia Eisman
15. Birthplace: Washington D.C.

16. Informant: Wife-Mrs. Ruth Naecker
Address: 4710 Park Lane, Suitland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 28, 1947 (month) (day) (year)
Cemetery or crematory: Oddy Hill
Location: Suitland, Md.
18. Funeral director: W.W. Chambers Co.
Address: 517-11th St. S.E. Washington D.C.

19. 8/25/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 1947 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22 1947 to Aug 24 1947 and that I last saw ... alive on August 24 1947

	DURATION
Immediate cause of death	
Due to: Coronary heart disease	3 days
Due to:	3 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William Brannin M. D. or Coroner
Address: Capitol Heights Date signed: 8/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67299

83 B

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Also correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3004 - Taylor, St.,

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME CHARLES HENRY NOBLE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	W	MARRIED

6.(b) Name of husband or wife: Sarah Ellen Noble

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): April 13, 1873

8. AGE: Years: 75 | Months | Days | If less than one day: ...hrs. ...min.

9. Birthplace: Ottawa, Kansas (Town, county, and state)

10. Usual occupation: Carpenter - Contractor

11. Industry or business

FATHER 12. Name: David Noble

13. Birthplace

MOTHER 14. Maiden name: Jane Brewster

15. Birthplace

16. Informant: Mr. Z. Jack Lewark

Address: 3004 - Taylor St, Mt. Rainier,

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 9 1947 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: 3201 - Bladensburg Rd. Colmar Manor

18. Funeral director: Williams J. Malley

Address: 3200 - Rhode Island Ave. Mt. Rainier md.

19. Aug 8 1947 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 7 1947 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 1947 to Aug 7 1947 and that I last saw him alive on Aug 5 1947

Immediate cause of death	DURATION
1. Cerebral Artery Thrombosis	4 yrs.
Due to: Generalized arterio-sclerosis	10 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Samuel J N Sugar M.D. M. D. or other

Address: Mt Rainier, Md Date signed: Aug 7, '47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

67310

CERTIFICATE OF DEATH

Reg. Diat. No. 745

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ Days

Hospital, institution, or street address where death occurred: Eugene Leland Memorial Hospital

How long in hospital or institution? 1½ Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: University Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4409 Sheridan Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mr. Joseph Vincent O'Hare

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife: Sarah Nina O'Hare

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 30, 1872

8. AGE: Years	Months	Days	If less than one day
74	9	18	..... hrs. ..... min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Real Estate Broker

11. Industry or business: Had own business

FATHER — 12. Name: George Albert O'Hare

FATHER — 13. Birthplace: Washington, D. C.

MOTHER — 14. Maiden name: Evelyn Mary Brown

MOTHER — 15. Birthplace: Missouri

16. Informant: Hospital Records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 20. 1947 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Washington D C

18. Funeral director: F Gaschi Sons

Address: Hyattsville Md

19. Aug 19 1947 (Date rec'd by registrar) Mona Jay Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17, 1947, at 1:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22 1947 to Aug 17 1947 and that I last saw him alive on Aug 17 1947

Immediate cause of death	DURATION
Congestive Heart Failure	5 Days
Due to: Bronchial pneumonia	3 Days
Due to:	
Other conditions: Transurethral Prostatectomy (June)	

(Include pregnancy within 3 months of death)

Major findings of operation: Prostatic Hypertrophy. Date of op. June 30, 1947.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: L W Maher MD M. D. or other

Address: 4408 Queensbury Road Riverdale, Maryland Date signed 8/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67301

Reg. Dist. No. 239

1. PLACE OF DEATH:

County: Prince Georges

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 7 years

Hospital, institution, or street address where death occurred: 320 Talbot Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Pr. Georges

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. 320 Talbot Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ella D. Orr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 18, 1865

8. AGE: Years: 82 | Months: 6 | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore, Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER — 12. Name: William Calvin Orr

13. Birthplace: Lamoinsburg, Pa

MOTHER — 14. Maiden name: Ellen Elizabeth Huston

15. Birthplace: East Liverpool Ohio

16. Informant: Mr. Charles Brooks, Nephew

Address: 320 Talbot Ave Laurel Md.

17. Burial (Burial, cremation, or removal. Which) Date thereof: Aug 26-1947 (month) (day) (year)

Cemetery or crematory: London Park

Location: Baltimore Md

18. Funeral director: De Witt Donaldson

Address: Laurel Md.

19. Aug 25 1947 M. Brashears

(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 26 1947 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947, to Aug 26 1947 and that I last saw h[illegible] alive on Aug 26 1947

	DURATION
Immediate cause of death: Softening of Brain	2 years
Due to:	
Due to:	
Other conditions: Hypertrophic arthritis	8 yr

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert L McGreevy M.D. M. D. or other

Address: 462 Main St Laurel Md. Date signed: 8/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67302

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos., 17 days

Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 6 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 1810 Second St., S. W. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: PINKIE LEE PARKER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: James Henry Parker

6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): March 1, 1922

8. AGE: Years	Months	Days	If less than one day
25	5	1	hrs. min.

9. Birthplace: ? North Carolina (Town, county, and state)

10. Usual occupation: Hospital Attendant

11. Industry or business: St. Elizabeth's

FATHER 12. Name: Frank M. Gilmore

FATHER 13. Birthplace: Philadelphia, Pennsylvania

MOTHER 14. Maiden name: Mary Parks

MOTHER 15. Birthplace: ? North Carolina

16. Informant: Deceased

Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Aug 2, 1947 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D. C.

18. Funeral director: Eugene Ford Co. by Hamm

Address: 1213 4½ St. S.W.

19. Aug. 2, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 2, 1947 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14, 1947 to Aug 2, 1947 and that I last saw her alive on Aug 2, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md., Date signed: Aug 2, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

67303

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year., 2 mos., 14 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 614 - 2nd St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: POSTELL, LOVISE

3.(b) Social Security Number: 578-30-0622

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Harry Postell

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): June 15, 1921

8. AGE: Years	Months	Days	If less than one day
26	2	5	hrs. min.

9. Birthplace: Lynchburg, South Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: -

FATHER
12. Name: Albert Davis
13. Birthplace: Lynchburg, South Carolina

MOTHER
14. Maiden name: Frances Lowery
15. Birthplace: Lynchburg, South Carolina

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8 20 47 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director: McIlvain & Selby Inc
Address 424 R. St. N.W.

19. 8/20 1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 20 1947, at 11 30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/5 1946, to 8/20 1947 and that I last saw her alive on 8/20 1947

Immediate cause of death	DURATION
pulm. tuberculosis	15 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 8/20/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92 b

67304

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Prince Geo. C
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Md. County: Pr. Geo. C
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5719-39th. Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: X

3. (a) FULL NAME: Francis Wm Price

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Liela S. Price
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 15 - 1898

8. AGE: 48 Years | Months | Days | If less than one day: hrs. min.

9. Birthplace: Iowa (Town, county, and state)

10. Usual occupation: mechanic

11. Industry or business

FATHER — 12. Name: Price
13. Birthplace: Iowa

MOTHER — 14. Maiden name: unknown
15. Birthplace:

16. Informant: Liela S. Price
Address: 5719-39th Ave Hyattsville

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug-26-47 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Wash. D.C.

18. Funeral director: W W Chaconas
Address: Riverdale - md.

19. Aug 25 1947 (Date rec'd by registrar) Mrs. Jas Devere (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug- 23 1947 at 10 55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 16 1946, to August 23 1947
and that I last saw h. alive on August 23 1947

Immediate cause of death	DURATION
Congestive Heart Failure	8+ mos
Due to: Chronic valvular disease (mitral stenosis)	15+ yrs
Due to: Rheumatic endocarditis	?
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: ~ Date of op.

Autopsy results: ~
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A B Norris M D
M. D. or other
Address: 2204 R. M. NW Date signed: 8/23/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

67305

Reg. Dist. No. 23 K

1. PLACE OF DEATH:

County: Prince George's

City or town: Accokeek Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Washington D.C. County:

City or town: 1412 Mass Ave N W Wash DC

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: MYRTLE R. PRICE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

B.(b) Name of husband or wife: Harry Price

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 17 1872

8. AGE:

Years	Months	Days	If less than one day
75			hrs. min.

9. Birthplace: W. Virginia (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business:

FATHER — 12. Name: Patrick Breenhan

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Mary Twist

15. Birthplace: Ireland

16. Informant: Mrs. Pearl Roth

Address: Accokeek Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 12-47 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Washington D C.

18. Funeral director: W. Marion Tattersall

Address: 2619-14th St N.W Wash, D C

19. 8-9 19 47 (Date rec'd by registrar) Mrs Alton Davis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9 19 47, at 9.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 8 19 47, to Aug 9 19 47

and that I last saw h... alive on August 8 19 47

Immediate cause of death	DURATION
Chronic Myocard.itis	8 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank Susan M. D. M. D. or other

Address: Indian Head Md Date signed 8/9/47.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07306

170c

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Prince George
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Dead on arrival
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Cheverly Manor
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3404 – 63rd Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Cathryn L. Rapter
3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Dec 29, 1924
8. AGE: Years 22 Months Days If less than one day ... hrs. ... min.
9. Birthplace Andrews, N.C. (Town, county, and state)
10. Usual occupation Clerk
11. Industry or business Army Motor Pool [illegible]
FATHER 12. Name Woody Rapter
13. Birthplace North Carolina
MOTHER 14. Maiden name Lola M. Snoddreth
15. Birthplace North Carolina
16. Informant C. W. Everly Jr.
Address 3404 - 63rd Place, Cheverly Manor
17. transportation Date thereof Aug 2, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Andrews
Location North Carolina
18. Funeral director L. Gasch's Sons
Address Hyattsville, Md.
19. Aug 2 1947 James Berry Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1 1947, at 7:30 P
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to Fracture of base of skull	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 8-1-47
Where did injury occur? East Riverdale P. G. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public Lane
Means of injury [illegible]
Deputy medical examiner
23. SIGNATURE [illegible] M. D. or other
Address [illegible] Date signed 8-1-47

VS A15 9-45-15M

JS

G7307

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46 f

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince George's
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days, 1 hr., 10 min.
Hoepital, Institution, or street addreee where death occurred:
Prince George's General Hospital
How long in hospital or Institution? 7 days, 1 hr., 10 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6409 State Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MR. CLAUDE REBECHI

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Santina Rebechi
6.(c) If alive, give age: years

7. Birth date of deceaeed (mo., day, yr.): January 5, 1902

8. AGE: Years	Months	Days	If lese than one day
45	7	14	hre. min.

9. Birthplace: Italy
(Town, county, and state)
10. Ueual occupation: Cement Finisher
11. Induetry or buainees:

FATHER
12. Name: Joseph Rebechi
13. Birthplace: Italy

MOTHER
14. Maiden name: Odell Bonetti
15. Birthplace: Italy

18. Intermant: S. A. Rebechi
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/22/47 (month) (day) (year)
Cemetery or crematory: Mt olivet Cemetery
Location: Washington D.C.
18. Funeral director: F. Gaeche sons.
Address: Hyattsville, Md. —

19. 8/21 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19, 1947, at 2:25PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 12 1947 to Aug 19 1947 and that I last saw h.i.m. alive on Aug 18 1947

Immediate cause of death	DURATION
Carcinoma of Pancreas	2 yrs.
Due to	
Due to	
Other conditions Metastasis to liver, stomach & peritoneum (Include pregnancy within 3 months of death)	

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death wae due to external causee, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Induetry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John D. Maloney M. D. or other
Address: Cheverly, Md Date eigned: 8-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

67308

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Forestville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred: Upper Marlboro R.F.D # 1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Forestville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emma Richardson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Franklin Richardson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 17 - 1867

8. AGE: Years: 80 Months: Days: If less than one day: hrs. min.

9. Birthplace: Penn.
(Town, county, and state)

10. Usual occupation: Housemaid

11. Industry or business: Own Home

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Penn.

MOTHER — 14. Maiden name: Emma Lynch

MOTHER — 15. Birthplace: Penn.

16. Informant: Dorothy C. Rutherford

Address: Forestville Md

17. removal (Burial, cremation, or removal. Which?) Date thereof: August 5-47 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: Arthur E. Simmons Jr.

Address: 2007 - Nichols Ave S.E.

19. Aug. 5 1947 (Date rec'd by registrar) Edna Collins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4 1947, at 9:30 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary occlusion	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Deputy medical Examiner

23. SIGNATURE: [signature] M. D. or other

Address: Forestville Md Date signed: 8-6-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

67309

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred: 4013 Longfellow st.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prin Geo
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4013 Longfellow
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Annie Robbins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 1879

8. AGE:

Years	Months	Days	If less than one day
67			..... hrs. ..... min.

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation: House Keeper

11. Industry or business: —

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Helen Jefferson
Address: 4013 Longfellow Hyattsville Md.

17. Burial — (Burial, cremation, or removal. Which?) Date thereof Aug 15, 1947 (month) (day) (year)
Cemetery or crematory: Evergreen Cemetery
Location: Bladensburg Md

18. Funeral director: E Gaschler Sons
Address: Hyattsville Md.

19. Aug 14 1947 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 13 1947 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Acute Congestive heart failure — DURATION
Due to: Cardiovascular renal disease
Due to:
Other conditions: Diabetes
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Deputy medical Examiner James J. Fong M. D. or other
Address: Forestville Md Date signed 8-13-47

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83 R

67310

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince Georges
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days -
Hospital, Institution, or street address where death occurred:
Leland memorial Hospital
How long in hospital or Institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4004 Oglethorpe St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mr. Charles Rodkey.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	

6.(b) Name of husband or wife Macy RodKey. (d)
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Oct 10-1876

8. AGE: Years	Months	Days	If less than one day
70	8	8	..... hrs. ..... min.

9. Birthplace Mayberry - Carroll Co. Md.
(Town, County, and state)
10. Usual occupation Carpenter
11. Industry or business self employed.
FATHER 12. Name William (Nelle) RodKey
13. Birthplace Md.
MOTHER 14. Maiden name Elizabeth Babylon
15. Birthplace Md.
16. Informant Mrs. Nellie Kilbreth
Address 4004 Oglethorpe St. Hyattsville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 4 47 (month) (day) (year)
Cemetery or crematory West Minister
Location West Minister Md
18. Funeral director W W Chambers Co
Address Riverdale, Md.
19. Aug 2 '1 1947 (Date rec'd by registrar) Mrs. Jas. Devere Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 1947, at 3 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1947, to Aug 2 1947 and that I last saw him alive on Aug 1 1947

Immediate cause of death	DURATION
Cerebral Thrombosis with left hemiplegia	1 week.
Due to Cerebral Arteriosclerosis	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE L W Malin M D
M. D. or other
Address Riverdale Md Date signed 8-2-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95 E

07311

CERTIFICATE OF DEATH

Reg. Diat. No. 246

1. PLACE OF DEATH:

County: Prince George's

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3420 - 36th St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Schott, Miss Bertha

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 26, 1873

8. AGE: Years 74 | Months 3 | Days 6 | If less than one day: hrs. min.

9. Birthplace: Washington D.C. (Town, County, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Brother's Home

FATHER 12. Name: Carl Anton Schott

13. Birthplace: ? Germany

MOTHER 14. Maiden name: Bertha Ida Gildemeister

15. Birthplace: ? Germany

16. Informant: Leland Memorial Hospital Records

Address: Riverdale, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 8 4 47 (month) (day) (year)

Cemetery or crematory: Crematory

Location: Fort Lincoln Cemetery

18. Funeral director: The D. H. Hines Co. ✓

Address: 2901 - 14th St. N.W.

19. Aug 1 1947 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 1, 1947, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1, 1947 to Aug 1 1947 and that I last saw h...er alive on 6-7-47 1947

Immediate cause of death: Rheumatic Heart Disease — DURATION

Due to:

Due to:

Other conditions: Advanced age

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. Rumsha, M.D. M. D. or Other

Address: 6204 - 44th Pl. Hyattsville Date signed: 8-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V8 A15 9-45-15M

07312

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 9 mos., 17 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 yrs., 9 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 314 McClain Ave., S. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SCOTT, JEAN CATHRINE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 22, 1934

8. AGE: Years	Months	Days	If less than one day
12	11	9	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: School girl
11. Industry or business: -

FATHER
12. Name: Walter Hudson
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Anna Mae Scott
15. Birthplace: Washington, D. C.

16. Informant: Deceased
Address

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 9 - 1 - 47 (month) (day) (year)
Cemetery or crematory: WOODLAWN CEM.
Location: D.C.

18. Funeral director: John T. Rhue + Co
Address: 901 - 3rd St. S.W.

19. Aug. 31, 1947 (Date rec'd by registrar) Rowland E. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31 1947, at 3 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/13 1944 to 8/31 1947 and that I last saw h... alive on 8/31 1947

Immediate cause of death: pulm. Tuberculosis — DURATION: 4 yrs.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Nature of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Md. Date signed: 8/31/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07313

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1860

CERTIFICATE OF DEATH

Reg. Diat. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince George's

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days

Hospital, Institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Bowie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Susie Shegogue (Susan R.)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 21, 1862

8. AGE: Years	Months	Days	If less than one day
85	5	17	hrs. min.

9. Birthplace: Prince George's County Md

(City, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Samuel Chaney

13. Birthplace: Mary; and

MOTHER 14. Maiden name: Martha — Chaney

15. Birthplace: Prince Georges Co. Md.

16. Informant: Doris E. Robey

Address: Bowie, Maryland

17. Burial, cremation, or removal? Burial Date thereof: Aug 10 1947 (month) (day) (year)

Cemetery or crematory: Holy Trinity

Location: Collington and

18. Funeral director: F. Gaesch's Sons

Address: Hyattsville Md.

19. (Date rec'd by registrar) 8/9 1947 Registrar: Amanda Dorsey

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 7 1947 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Myocardial insufficiency	
Due to: Fracture of the left hip	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 7/17/47

Where did injury occur? Bowie P. G. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Fell from a chair Injured at work? No

23. SIGNATURE: Deputy Medical Examiner

M. D. or other

Address: Forestville, Md. Date signed: 8/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

120a

67314

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges co
City or town: Bladensburg Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred: 4618 Anapolis Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Georges
City or town: Bladensburg Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4618 Anapolis Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Ella Swift

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, ~~widowed, or divorced~~
Female	col	married

6.(b) Name of husband or wife: Seabron Swift
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): 1882

8. AGE: Years: 65 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Elberton Ga. (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Home

FATHER
12. Name: William Maxwell
13. Birthplace: Ga.

MOTHER
14. Maiden name: Manervia Thornton
15. Birthplace: Ga.

16. Informant: Seaborn Swift
Address: 4618 Anapolis Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/26/47 (month) (day) (year)
Cemetery or crematory: Fairview Cemetery
Location: Annapolis Rd. Pr. Ges. Co. Md.

18. Funeral director: Robert G. McGuire
Address: 1820-9th St N W

19. 8/23 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 23 1947 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 21 1947, to Aug 23 1947
and that I last saw h alive on Aug 21 1947

Immediate cause of death	DURATION
acute Gastro-enteritis	3 day
Due to,	
Due to,	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W G Hudson M.D.
M. D. or other
Address: 3530 N H Ave N W Date signed: Aug 23 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

67315

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ine correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:
County Prince Georges Md.
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 hrs 20 min.
Hospital, institution, or street address where death occurred:
Pr. Georges Hosp
How long in hospital or institution? 14 hrs 20 min

2. USUAL RESIDENCE (HOME) OF DECEASED.
(For newborn infants give residence of mother)
State Md. County Pr. Geo.
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3818 - 31st. St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Setlow, Mrs. Winifred

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife Daniel L.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 18, 1882

8. AGE: Years 65 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual occupation L.W.

11. Industry or business

FATHER 12. Name John Dwyer
13. Birthplace Ireland

MOTHER 14. Maiden name Nellie Murphy
15. Birthplace Ireland

16. Informant Husband - Daniel L— Address Same

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-1-1947 (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Bladensburg Rd. N.E. Wash. D.C.

18. Funeral director Wm J. Bailey

Address 3200 R.I. Ave Mt Rainier Md.

19. 8/30 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29 1947 at 1 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 11 1947 to Aug 29 1947 and that I last saw h[illegible] alive on Aug 28 1947

	DURATION
Immediate cause of death Pulmonary Embolism	
Bronchopneumonia	2 weeks
Due to Arteriosclerotic Heart Disease	5 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Benjamin S. Miller M. D. or other

Address 3824 - 34th St Mt. Rainier Date signed 8/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46b

07316

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince George
City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? five years
Hospital, Institution, or street address (where death occurred):
4030 Webster St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4030 Webster St
(If rural, give LOCATION)
2.(a) If veteran, name war none

3.(a) FULL NAME James Dewey Washington

3.(b) Social Security Number 578-09-6934

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Dadie Washington
6.(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) October 7, 1899

8. AGE:	Years	Months	Days	If less than one day
	47			....hrs. ....min.

9. Birthplace King George Co. Va.
(Town, county, and state)
10. Usual occupation Truck Driver
11. Industry or business Truck driver

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden name Virginia Washington
15. Birthplace Va

16. Informant Dadie Washington
Address 4030 Webster St. Brentwood Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof aug 6 1947 (month) (day) (year)
Cemetery or crematory
Location 1432 Yor St N W
18. Funeral director E Ernest Jarvis Co
Address 1432 Yor St NW

19. Aug 6 1947 (Date rec'd by registrar) A. James Seevers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1947 at 6:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 1947, to August 6 1947
and that I last saw him alive on August 5 1947

Immediate cause of death	DURATION
Carcinoma of Stomach	7 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Smallwood Cichios, M.D. M. D. or other
Address 681 Mass. N.W. Washington D.C. Date signed 8/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07317

1310

Reg. Diat. No. 232

1. PLACE OF DEATH:

County Prince Georges

City or town Rosaryville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, Institution, or street address where death occurred:

Cram / Highway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Rosaryville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Cram / Highway

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Elizabeth Washington

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1900

8. AGE: Years 47 | Months | Days | If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own Home

FATHER

12. Name Moses Washington

13. Birthplace Maryland

MOTHER

14. Maiden name Emma Hager

15. Birthplace Maryland

16. Informant Albert Washington

Address Cheltenham, Md.

17. Burial Date thereof 8-16-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rosaryville

Location Rosaryville, R. Pr. Co. Md.

18. Funeral director Fisher Bros.

Address Upper Marlboro, Md.

19. Aug 15 1947 R. Emmart Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13 19 47 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 , to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
(a) acute congestive heart failure	
Due to (b) Cardiovascular renal disease	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

reports medical examiner

23. SIGNATURE James D. Lloyd M. D.

Address Forestville, Md. Date signed 8-13-47

PLEASE WRITE PLAINLY, WITH PENCIL OR INDELIBLE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07318

1310

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Mt Rainier
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, Institution, or street address where death occurred:
4401 - 32nd Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town: Mt Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4401 - 32nd Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alice Emily Webb

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 10 1862

8. AGE: Years 84 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace England (town, county, and state)

10. Usual occupation Nurse

11. Industry or business

FATHER 12. Name William Webb
13. Birthplace England

MOTHER 14. Maiden name Harriette White
15. Birthplace England

16. Informant John H. Webb
Address 4000 Cuttenden St Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 18, 1947 (Month) (day) (year)

Cemetery or crematory St Johns
Location Bettsville Md

18. Funeral director E Gaschen Sons
Address Hyattsville Md.

19. Aug 16 1947 (Date rec'd by registrar) Mrs Jas Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1947, at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive Heart failure	
Due to Cerebro vascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Deputy medical Examiner James D Rock M.D. or other
Address Hyattsville Md. Date signed 8-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170 C

67319

CERTIFICATE OF DEATH

Reg. Diat. No. 232

1. PLACE OF DEATH:

County: Prince George's

City or town: T. B. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death: Temporary

Hospital, institution or street address where death occurred: Route 301

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Balto

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 419 7 Street (If rural, give LOCATION)

2.(a) If veteran, name war: K

3.(a) FULL NAME: Hugh Egerton Williams Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 5, 1923

8. AGE: Years: 23 Months: Days: If less than one day: hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: A. M. M. 1/C

11. Industry or business: U. S. Navy

FATHER 12. Name: Hugh Egerton Williams, Sr.

FATHER 13. Birthplace: Ohio.

MOTHER 14. Maiden name: Marguerite Capp.

MOTHER 15. Birthplace: New York

16. Informant: U.S. Navy Dept.

Address: Washington D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 20 1947 (month) (day) (year)

Cemetery or crematory: W. H. Chamberlain Co.

Location: 1400 Chapin N.W. Washington D.C.

18. Funeral director: W. H. Chamberlain Co.

Address: 1400 Chapin N.W. Wash D.C.

19. Aug 20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20 1947, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Crushed chest	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 8-20-47

Where did injury occur? T. B. (City or town) P. G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Route 301

Means of injury: Collision Injured while: Riding Motorcycle

23. SIGNATURE: (Signed) [illegible] M. D. or other

Address: Forestville Md. Date signed: 8-20-47

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07320

932

CERTIFICATE OF DEATH

Reg. Diat. No. 345

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: Brentwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4409 - 37th St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mr. Albert Peter Windheim

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married.

6.(b) Name of ~~husband or~~ wife: Margaret E.J. Windheim
6.(c) If alive, give age: 64 years
7. Birth date of deceased (mo., day, yr.): aug -7- 1882

8. AGE: Years	Months	Days	If less than one day
65		19	hrs. min.

9. Birthplace: Utica New York (Town, county, and state)
10. Usual occupation: Butcher
11. Industry or business: Sheirs. U.S. Market.
FATHER 12. Name: George Windheim
13. Birthplace: Germany
MOTHER 14. Maiden name: Mary Louise ?
15. Birthplace: France
16. Informant: wife
Address: 4409 - 37th St. Brentwood Md.
17. Disposition: transportation (Burial, cremation, or removal, which?) Date thereof: Aug 27. 1947 (month) (day) (year)
Cemetery or crematory: St Josephs Cemetery
Location: Utica New York
18. Funeral director: F Gaschi Sons
Address: Hyattsville Md
19. Aug 27 1947 (Date rec'd by registrar) Thos Jas Lovell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 26. 1947 at 6 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 9. 1947 to Aug 26 1947 and that I last saw him alive on August 28 1947

Immediate cause of death	DURATION
Pulmonary Embolism	10 min
Due to Coronal Thrombosis of Leland	1 wk ?
Due to Cerebral Vascular Accident	18 days
Other conditions Hypertension & Hypertensive Heart Disease (Include pregnancy within 3 months of death)	? Yrs.

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. G. Gibson M.D.
M. D. or other
Address: Riverdale, Md. Date signed: 8-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

07321

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges County
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred:
Prince Georges Hospital
How long in hospital or Institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: North Carolina County:
City or town: High Point
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Walser, Mr Zenobian

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	married

6.(b) Name of husband or wife: Alma - wife
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1873

8. AGE:

Years	Months	Days	If less than one day
74			hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Attorney

11. Industry or business

FATHER 12. Name: Mr. Father Walser
13. Birthplace: North Carolina

MOTHER 14. Maiden name: Mrs. Frances Byerley
15. Birthplace: [illegible], N.C.

16. Informant: Wife - Alma -
Address: c/o Mrs. E Chaney - Bristol, Md

17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof Aug 28 1947 (month) (day) (year)
Cemetery or crematory: CEMETERY
Location: HIGH POINT, N.C.

18. Funeral director: T. A. HARDESTY & SON
Address: GALESVILLE, MD

19. 8/28 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 Aug 1947, at 12 20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 Aug 1947 to 28 Aug 1947 and that I last saw h[illegible] alive on 28 Aug 1947

	DURATION
Immediate cause of death: Cerebral Thrombosis	8 days
Due to: Peripheral Circulatory Collapse	24 hours
Due to: Carcinoma of Liver	2 yrs
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE R M Fraser M. D.
Address: Upper Marlboro, Md Date signed:

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.